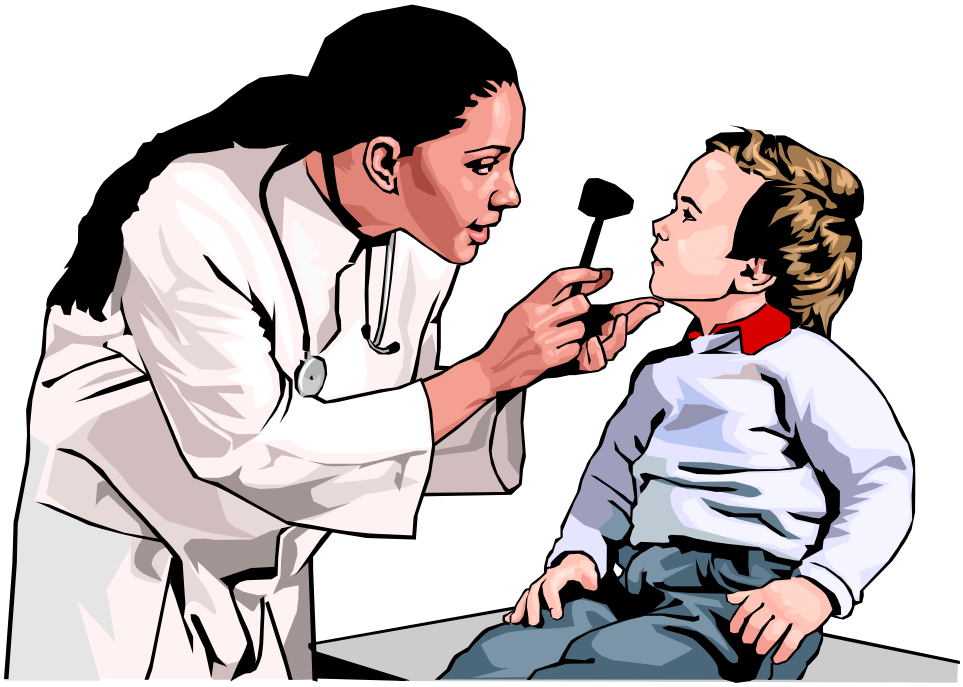
The State of Wisconsin's
Medicaid Eligibility Quality Control
2002



The impact of Medicaid program simplification and streamlined verification changes on customers, workload and eligibility determinations

Executive Summary

Within the last six years, the Department of Health and Family Services has taken steps to expand coverage and streamline enrollment into public health care programs for low-income Wisconsin families. For example, asset limits have been eliminated for Family Medicaid (including BadgerCare) and coverage has been expanded to applicants with income up to 185% of the federal poverty level. In addition, the Department has simplified the Medicaid application process through development of a two-page, mail-in family Medicaid application form, elimination of the requirement for an in-person interview and streamlined verification requirements. The basic tenet of the program simplification and streamlined verification changes is to use available data exchange resources and require Medicaid applicants to provide verification only for mandatory items or those items that are deemed "questionable" by eligibility workers in accordance with Department policy.

The primary goals of Wisconsin's 2002 MEQC project were to:

- Assess the impact of program simplification and streamlined verification changes on the accuracy of Medicaid eligibility determinations.
- Evaluate the impacts of program simplification and streamlined verification changes on customer service and the workload of local human/social service agencies.
- Identify areas to target for policy and process improvements.

To assess the impact of program simplification and streamlined verification changes on the accuracy of Medicaid eligibility determinations, both active and negative case actions were reviewed to determine if the certification, denial or termination was correct. To assess the impact on customer service and workload, surveys of eligibility workers, Medicaid applicants/recipients and advocacy agencies were conducted.

Analysis of the case reviews indicated that overall there was a very low incidence of errors. Ninety-two percent of the Medicaid certifications reviewed were considered correct: the recipient met all non-financial and financial eligibility criteria. Of the 8% considered in error, 6% were the result of income errors, and 2% were due to non-financial factors such as residency and household composition. In all except one of the income error cases, the incorrect certification resulted from an applicant's failure to accurately report income at application or failure to report income changes during the certification period. Approximately $3.8 billion is spent annually on Medicaid benefits. The total amount of claims established for client errors identified in this evaluation were just over $32,000.

Evaluation of cases where Medicaid was denied or terminated also indicates that Wisconsin has very few incorrect eligibility determinations. Of the 228 negative case actions reviewed, 206 were considered correct: the applicant or recipient received adequate notification of required information/verification and negative action was not taken until adequate time to produce required documents or information had passed. Twenty-two denials or terminations were considered to be in error because the applicant/recipient was not properly notified of information and/or verification required for Medicaid, or because adequate time was not allowed to produce required verification before negative action was taken.

Medicaid applicants and the community-based organizations that provided assistance to them were surveyed to assess how simple the mail-in application form was to complete and submit,

how much assistance was typically needed, and which aspects of the application process were problematic for applicants. It is difficult to assess the effect that professional assistance may have had because survey respondents did not likely represent the majority of users of the application form. However, survey data indicates that applicants found the application form easy to complete but also recognize that expert assistance is valuable. Advocates feel that the application form allowed them to become more involved in helping their clients apply for Medicaid and slightly improved communication with eligibility workers.

The Department also surveyed eligibility workers about their experiences with program simplification and streamlined verification changes. Survey data indicates that eligibility workers perceive that program simplification and streamlined verification changes have made the application process easier for customers, but have also increased local agency workload. The Department recognizes these concerns and with this has embarked on a number of initiatives to reduce local agency workload.

Recently, Wisconsin implemented a number of changes to reduce workload, ensure excellent customer service and increase program integrity. For example, enhancements have been made to data exchange processes and a new web page has been developed. The web page is designed to be a "one stop shop" for local agency workers to find forms, publications, Operations Memos, frequently asked questions, etc. In addition, clarifications to the Medicaid eligibility handbook were incorporated and changes to further align Medicaid policy, Food Stamp policy and the CARES system have been implemented. Many additional improvements are scheduled to occur over the next year. These include an automated case directory, web-based library and user interface, additional automatic updates from third party sources and mini driver-flows. All of these enhancements will reduce local agency workload and increase program integrity.

Overall, the implementation of program simplification and streamlined verification is considered a success. However, to further balance the goals of program access, reduction in local agency workload and program integrity, a continued focus on the enhancement of data exchange resources is recommended. Data exchange resources have the potential to reduce workload, increase the accuracy of eligibility determinations and minimize barriers to health care coverage for eligible Wisconsin families. In addition, revision of the Medicaid mail-in application forms and further emphasis on corrective action and benefit recovery is recommended.

Table of Contents

Background

Wisconsin's Department of Health and Family Services administers Medicaid through contracts with seventy-nine local social/human service and tribal agencies. To determine and manage eligibility for the Medicaid, Food Stamp and TANF programs, public eligibility workers use the state-managed Client Assistance for Re-employment and Economic Support (CARES) automated system. CARES is a mainframe system used by eligibility workers as a case processing tool and the Medicaid Management Information System (MMIS) is used for Medicaid identification card issuance and claims reimbursement. CARES stores information obtained through the application process, provides guidance for necessary case action and eligibility decisions and issues notifications about eligibility and program requirements. CARES has 28 subsystems organized under six general areas: application processing, case management, financial information, management information, employment and training and support functions.

In determining eligibility for Medicaid, an eligibility worker collects information and required verification, and enters this data into CARES. If additional information or verification is required to determine eligibility, the applicant is notified through CARES and the eligibility worker is automatically alerted when it is due. If an applicant is determined ineligible for Medicaid, s/he receives written notification of the reason(s) for ineligibility and information about the appeal process.

If Medicaid eligibility is certified in CARES, the eligibility information is transmitted to the MMIS automated system and a recipient identification card is issued if the recipient is newly eligible. In most circumstances Medicaid eligibility is tentatively certified for 12 months but recipients are required to report certain changes in circumstance during the certification period. If a reported change results in ineligibility, recipients are notified at least ten days prior to the effective date. An ex-parte review of Medicaid eligibility occurs at the end of the certification period.

In response to declining Medicaid enrollment after welfare reform in the mid-1990's, the State of Wisconsin took steps to remove barriers and increase access to health care for low-income Wisconsin families. Specifically, coverage has been expanded to uninsured families with income up to 185% of the federal poverty level and asset limits have been eliminated for Family Medicaid, including BadgerCare. In the past, applicants and recipients were required to meet non-financial and financial requirements, complete an in-person interview and provide proof of their non-financial and financial circumstances in order to be determined eligible for Medicaid.

In July 2001, the Department simplified the Medicaid application process by developing a two-page, mail-in family Medicaid application form, eliminated the requirement for an in-person interview and minimized client verification requirements. The basic tenet of the program simplification and streamlined verification changes is to use available data exchange resources and require Medicaid applicants to provide proof only for mandatory items or those items that are deemed "questionable" by eligibility workers in accordance with Department policy.

As a result of the sluggish economy and program expansions, Wisconsin's family Medicaid caseload increased throughout 2002 and is currently at a record high. States are required by the federal government to evaluate an aspect of Medicaid benefit issuance, and Wisconsin sought information about how to increase program integrity and minimize inappropriate expenditures. For federal fiscal year 2002, the Centers for Medicare and Medicaid Services (CMS) approved Wisconsin's request to further evaluate the program simplification and streamlined verification changes which were implemented statewide in July 2001.

Introduction

The Department's Vision and Mission

The Department vision is making wellness and safety happen. The Department's mission is to lead the nation in fostering healthy, self-reliant individuals and families. As part of this mission, the Department seeks to:

- Improve the health status of the people of Wisconsin
- Provide excellent customer service
- Assure program integrity
- Reduce administrative costs
- Stimulate the state's economy through increased federal revenue

Goals of the 2002 MEQC project

The primary goals of Wisconsin's 2002 MEQC project were to:

- Assess the impact of program simplification and streamlined verification changes on the accuracy of Medicaid eligibility determinations.
- Evaluate the impacts of program simplification and streamlined verification changes on customer service and the workload of local human/social service agencies.
- Identify areas to target for policy and process improvements.

Evaluation Methods

To assess the impact of program simplification and streamlined verification changes on the accuracy of Medicaid eligibility determinations, both active and negative case actions were reviewed to determine if the certification, denial or termination was correct. To assess the impact on customer service and workload, surveys of eligibility workers and Medicaid applicants/recipients were conducted.

Case Reviews

Active Sample

A random sample of 380 active cases was drawn from the universe of family Medicaid cases, and 353 active cases were reviewed to determine if the Medicaid certification was correct. Family Medicaid cases were identified by the assigned medical status code and included those where certification occurred between October 2001 and September 2002. We targeted cases where Medicaid was certified for the first time, or those where Medicaid had been closed for at least one calendar month before re-certification.

Negative Sample

In addition to the active sample, a random sample of 228 family Medicaid cases where a negative case action (denial or termination of Medicaid) occurred between October 2001 and September 2002 was drawn. Negative cases were reviewed to determine whether the denial or termination was warranted, and if proper procedures were followed.

Surveys

To evaluate the impacts of program simplification and streamlined verification changes on customer service and the workload of local social service agencies, two surveys were administered. The Department contracted with an advocacy agency, ABC for Health, to conduct a customer service survey of Medicaid applicants who received professional assistance and the community-based organizations that provide assistance to them. In addition, a survey of eligibility workers was conducted by the Department to solicit input about the impact of changes on their workload and Medicaid applicants and recipients.

As expected, the case reviews and surveys provided an effective means to measure the impact of program changes. Analysis of the data yielded useful information about performance and the areas to target for policy and process improvements.

Findings

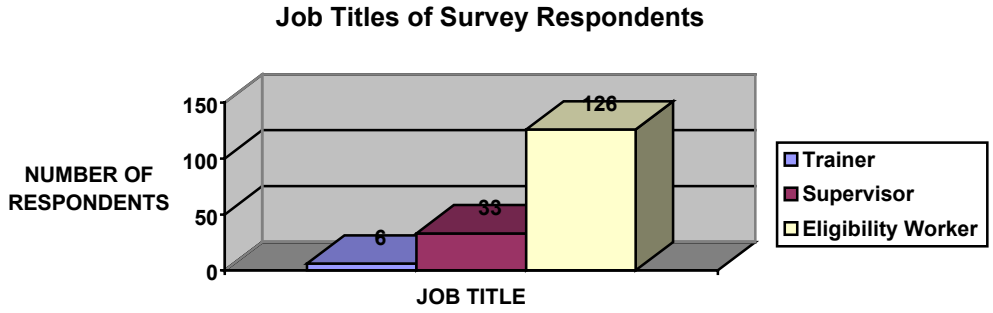
The impacts of program simplification and streamlined verification changes on workload.

Survey of Eligibility Workers

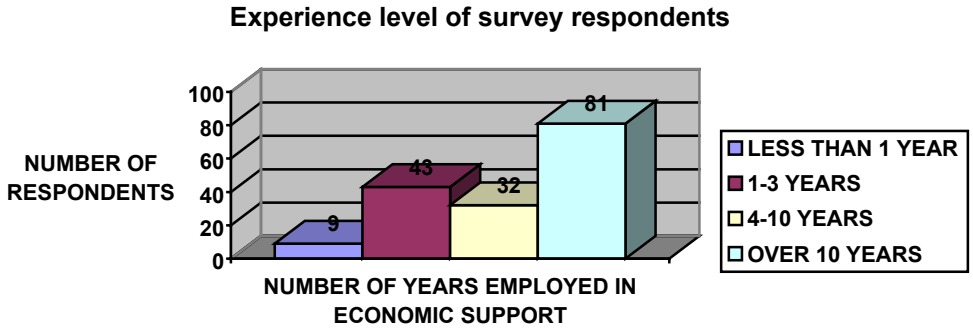
A survey was distributed electronically in November 2002 to the 79 agency-designated coordinators with instruction to distribute to all eligibility workers and their supervisors. The survey included seven multiple-choice questions and a place to indicate comments and suggestions.

Survey Respondent Information

A total of 165 responses were received. The majority of respondents (76%) were eligibility workers. In addition, several supervisors stated that the survey was discussed at a team meeting and their responses also represented the opinions of the eligibility workers whom they supervise.

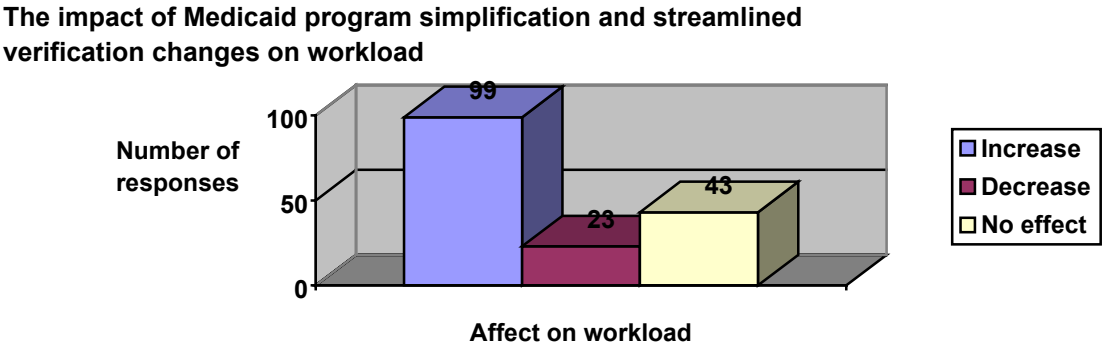


At the time of this survey, almost half of the respondents had worked in the Economic Support field for over ten years. Ninety-five percent of the respondents had worked in the Economic Support field for over one-year so nearly all of the survey respondents had experience with Medicaid eligibility determinations before program simplification and streamlined verification changes were implemented.

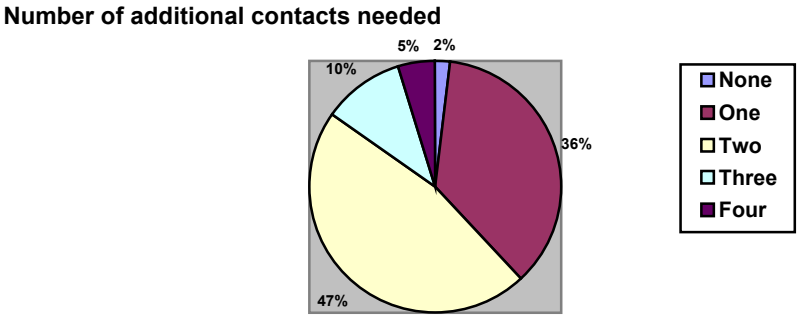


Survey Responses

Respondents were asked how the Medicaid program simplification and streamlined verification changes have affected their workload. Sixty percent of the respondents stated the changes caused their workload to increase. Fourteen percent stated that their workload decreased as a result of the changes, and 26% said the changes had no effect on their workload.



Survey respondents were also asked on average, how many additional contacts are needed to obtain required information after a mail-in application is submitted. Almost half of the respondents stated two additional contacts are necessary to obtain information needed to determine Medicaid eligibility, and nearly all stated that at least one additional contact was needed to process a mail-in application.



Summary of Respondents' Suggestions

In the comment section of the survey, many eligibility workers expressed concern with the mail-in form and application process. It is important to eligibility workers that applicants receive adequate information about Medicaid and other programs of assistance. Several respondents stated that from their perspective the loss of face-to-face contact that occurs with a mail-in application is not conducive for communicating information about Medicaid program requirements, rights and responsibilities, other programs of assistance, etc.

Eligibility workers also discussed the impacts of program simplification and streamlined verification changes on program integrity and their workload. It is important to eligibility workers that their Medicaid eligibility determinations are accurate. Many respondents feel the application form does not collect all of the information necessary to accurately determine eligibility and that applicants frequently misunderstand application instructions, or tend to list only those household members who are applying for Medicaid.

In addition, several respondents commented about the workload associated with errors that result from mail-in application forms that are incomplete or inaccurate. An incomplete and/or inaccurate application results in additional time spent gathering information through subsequent phone and mail contacts. Application errors discovered during the certification period result in additional time spent on data exchange and benefit recovery activities.

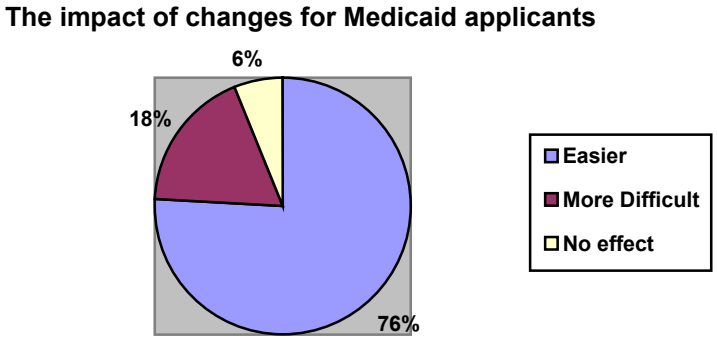
It should be noted that the Department has been working over the past few years to remove barriers in accessing services, which is a departure from previous models of service delivery. It is possible that some local agency workers are in the process of shifting paradigms.

The Impacts of Program Simplification and Streamlined Verification on Customers

DHCF Survey of Eligibility Workers

Local agency survey respondents were also asked how program simplification and streamlined verification changes have impacted customers. The majority (76%) of respondents stated the changes have made the Medicaid application process easier for customers. Six percent of the respondents did not think the program simplification and streamlined verification changes had an effect on customers, and 18% feel the changes have made the application process for Medicaid more difficult.

Summary of ABC for Health Report



The Wisconsin Division of Health Care Financing (DHCF) contracted with a Wisconsin advocacy agency, ABC for Health, to conduct a survey of individuals using the simplified Medicaid/BadgerCare application process which includes a mail-in option and streamlined verification requirements. The primary goals of the survey were to measure how simple the form was for customers to complete and submit, how much assistance was typically needed and which aspects of the new application were problematic. Both customers and the health care

organization or community-based organizations that helped customers were surveyed so that their differing perspectives and experiences with the process could be assessed.

Survey Participants

- A total of 123 surveys were distributed to participating organizations, based on ABC's estimate of how many organizations were involved in helping families with the Medicaid application process. Of these, 32 organizations returned surveys.

- A total of 975 client survey packets were distributed to participating organizations, based on agency estimates of how many clients were typically served each month. Of these, 87 client surveys were returned (74 in English, 13 in Spanish).

Survey Results

The basic picture that emerges from the survey responses received from both customers and the organizations that assist them is as follows:

Customers

The form succeeds in being simple and quick for customers to complete. However, the majority of customers recognize that expert assistance is valuable and feel less confident about completing the application on their own. Most customers received help from community-based organizations and had the organization submit the form on their behalf, generally by mail. Customers are typically young, high school educated, married, and have small families or children on the way.

Community-based Organizations

Most community-based organizations feel that the new form has allowed them to get more involved in helping their clients apply for coverage and has slightly increased their contact with economic support staff, resulting in better communications and collaboration with them. They recognize the need for expert assistance, and most feel responsible enough about their role to have some method of tracking their involvement, generally by keeping a copy of the form or keeping a record of their activities. Nearly all received training on the simplified form and felt well prepared by the training they received. Yet they felt the need for additional supportive resources and showed greatest interest in consumer education materials and guides, access to Medicaid policy manuals and memos, and opportunities to meet with eligibility workers.

Specific Community-based Organizations Findings

- The majority of community-based organizations (88%) felt that the new form and process allowed them to be more involved in helping their clients apply.

- Most community-based organizations (72%) reported providing substantial assistance to clients.

- Most community-based organizations (72%) were able to complete the form in one sitting and none of the respondents indicated the form was "very difficult" for their clients to complete.

- Because community-based organizations completed one survey to summarize their experiences helping multiple clients with the application form, most were able to recall some instance where clients had problems supplying information for the application. The greatest area of difficulty noted was absent parent information (79%), followed by Social Security Numbers (62%) and income information (52%).

- The majority of community-based organizations have a method to track the applications they help to complete.

- Overall, a slight majority of respondents (41%) felt their contact with economic support workers had increased as a result of the new form. Roughly a third experienced no change in contact, and 28% thought contact had decreased.

- The majority (94%) of the thirty-two community-based organizations surveyed had received some kind of training or orientation to the new application form and process.

Specific Customer Findings

- The majority of client respondents (85%) had assistance filling out the form and a community-based organization (rather than friend or family member) helped all of the respondents who received assistance. All respondents found the assistance they received from community-based organizations helpful.

- The majority of clients (86%) reported having completed the application within half an hour, and for most it took less than fifteen minutes. However, it tended to take slightly longer for those that did not receive any assistance from a community-based organization.

- Most clients (85%) were able to complete the application in one sitting. Most respondents (79%) indicated that they had documentation they needed for the application with them or had no trouble getting it.

- In most cases, the application was mailed (64%) or hand-delivered (25%) to the county or tribal human/social services office.

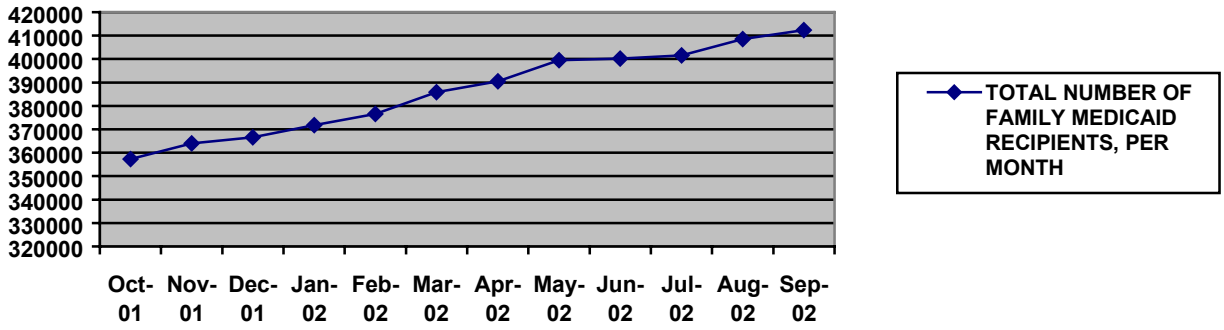
- Nearly 90% of families ranged in size between two and five members, with the majority being households of three. Most clients were young, in their twenties. Less than 20% were age 40 and above. Less than a third had any education past secondary school. High-school graduates or GED holders comprised 43% of the respondents. A quarter had not completed high school.

- Most respondents were white (63%), American Indian (17%) or Latino (17%). There were not any African American or Asian respondents.

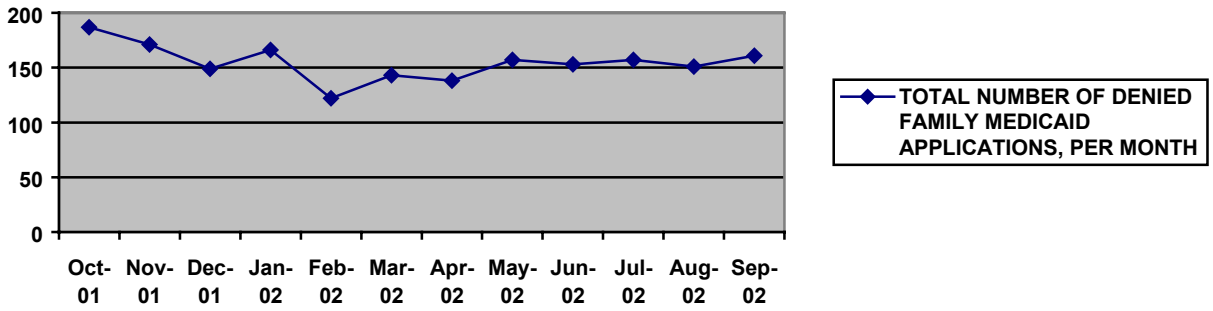
Case Reviews: Sample Information and Review Methodology

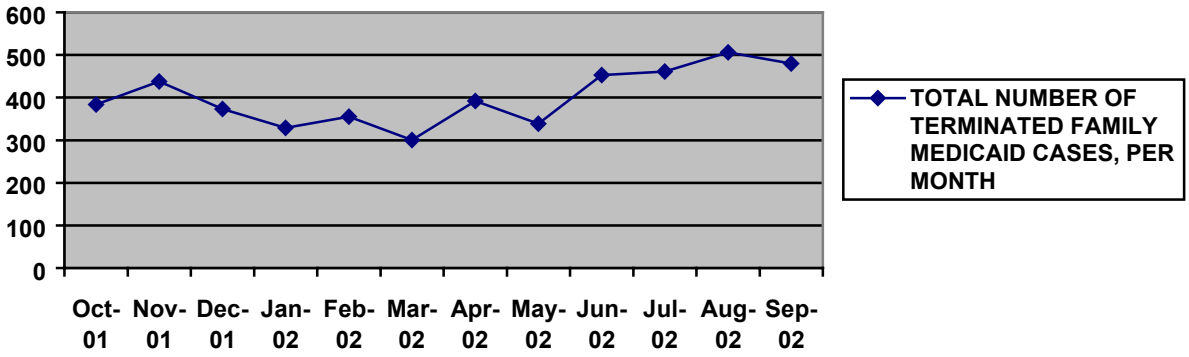
Sampling Universe and Methodology

Family Medicaid Active Universe Information



Family Medicaid Negative Universe Information





Active Sample

A random sample of 380 cases was drawn from the universe of family Medicaid cases and a total of 353 cases were reviewed. Twenty-seven reviews were not completed for one or more of the following reasons:

- Contact information for the recipient's employer was not reported at application, collected prior to Medicaid certification or available to reviewers through data exchange (4).
- The employer failed to respond to requests for income verification (7).
- The fiscal test group contained a non-qualifying immigrant who stated that s/he works for cash (2).
- There was indication that an "absent parent" was living in the household but household composition and family income could not be determined without further investigation (1).
- The recipient was self-employed and data exchange information was unavailable, but s/he failed to respond to requests for verification of income (4).
- The local agency was not able to locate the case file (7).
- The recipient received unemployment compensation income in a neighboring state, but the state failed to respond to a request for verification of income (1).
- There was indication that the recipient had moved out of state but her whereabouts could not be determined without further investigation (1).

Sample cases were identified by the assigned medical status code and included those where certification occurred between October 2001 and September 2002. An additional targeting criteria identified cases where Medicaid was certified for the first time, or those where Medicaid had been closed for at least one calendar month before re-certification.

The non-financial and financial eligibility of household members in the fiscal test group was reviewed to determine if the certification was correct. The non-financial eligibility review included an examination of residency, child support and SSN cooperation requirements, household composition/living arrangement, age, and citizenship. Financial eligibility was tested at 185% of the federal poverty level for applicants and 200% of the federal poverty level for recipients of the program.

Reviewers used third party data exchange resources and collateral contacts to obtain information about the recipient's income, age, state of residency, household composition, and cooperation with social security requirements and the child support agency. The review focus was on the correctness of the certification: that the recipient met all non-financial and financial program requirements. Although Medicaid costs incurred as the result of an incorrect certification were gathered as part of this evaluation, they were not a consideration in the designation of error.

Review results on all cases were communicated to local agencies and corrective action (re-determine eligibility and/or assess whether an overpayment occurred) was requested for any case in which an error was discovered. Although the review focused primarily on the initial month of certification and subsequent month, local agencies were notified when during the course of

review a potential error in the remaining certification period was discovered. In the cases where it was determined that an error in the remaining certification period occurred, it was documented as such and included in the error statistics.

Negative Sample

A random sample of 228 family Medicaid cases in which a negative case action (denial or termination of Medicaid eligibility) occurred were also reviewed. The sample included cases where the denial or termination occurred between October 2001 and September 2002. To focus on the program changes being evaluated, the termination and denial reason codes were limited to those where applicants failed to provide and/or verify information, or failed to complete the application process. Other sample parameters included the following:

- Terminated cases were defined as having been closed for at least one calendar month.

- The sample consisted of cases in roughly the same proportion as the negative actions in the entire universe. For example, in October 2001 the entire negative universe was 571, which consisted of 384 terminations and 187 denials. The proportionate sample consisted of 14 (74%) cases with terminations and 5 (26%) cases with denials.

The denial/termination reasons requested for selection of sample cases included the following:

Numerical Reason Code	Denial/Termination Text
38	Primary person failed to verify identity
42	Failed to cooperate in establishing eligibility
50	Withdrew entire application
78	Failed to complete the application
112	Did not verify information
113	Failed to provide information

The primary focus of review for negative cases was to evaluate the implementation of program simplification and streamlined verification changes: did the elimination of verification requirements prevent unnecessary denials and terminations? To measure this, reviewers determined whether adequate notice of verification requirements was provided and if the time allowed to produce verification had passed before eligibility was denied or terminated.

Eligibility workers were instructed to deny/terminate Medicaid eligibility for failure to provide verification only when there is substantial reason to question the validity of information provided by the client, and adequate time to produce it has passed. According to the Medicaid Eligibility Handbook, verification of non-mandatory items should only be sought when self-declared information is deemed "questionable." Eligibility workers were instructed to seek verification of non-mandatory items from the applicant/recipient when:

- There are inconsistencies in the group's oral or written statements.

- There are inconsistencies between the group's claims and collateral contacts, documents or prior records.
- The client or his/her representative is unsure of the accuracy of his/her own statements.
- The client has been convicted of Medicaid recipient fraud or has legally acknowledged his/her guilt of recipient fraud.

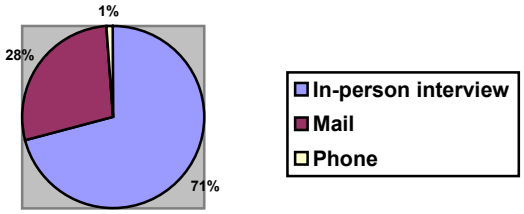
Eligibility workers were instructed to apply Medicaid verification requirements even when the applicant also applied for other programs of assistance, but 42% of the Medicaid applicants in sample cases also received food stamps and/or TANF benefits (Child Care or Wisconsin Works) during the month of application for Medicaid. The verification requirements of those programs are more prescriptive, and in many cases impacted the Medicaid eligibility determination. For example, if verification of income was requested for food stamps and was not provided, in some cases eligibility for both Medicaid and Food Stamps was denied.

The Impacts of Program Simplification and Streamlined Verification on the Application Process

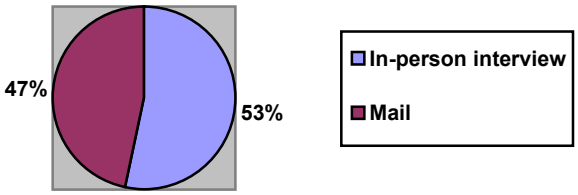
Application Method

The application method for all active cases was compared with those active sample cases where Medicaid was the only program of assistance requested to assess the extent to which Medicaid applicants used the mail-in option. In the entire sample, 71% of applicants completed an in-person interview, 28% of applications were submitted and processed by mail and 1% were processed by phone. Although an in-person interview is no longer required for Medicaid, less than half of the Medicaid-only applicants used the mail-in application method.

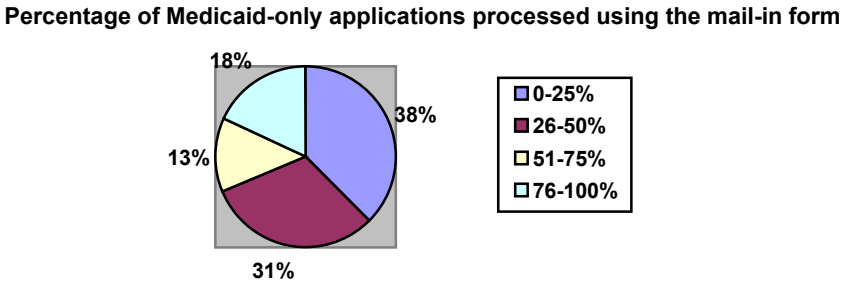
Application method for all active cases reviewed



Application method for Medicaid-only cases



Survey respondents were asked what percentage of Medicaid-only applications are processed in their agency using the mail-in application forms. Thirty-eight percent of respondents stated less than 25% of Medicaid-only applications were processed using the mail-in forms. In the Medicaid-only cases reviewed, 47% were processed using the mail-in application form. We cannot ascertain from the review instrument why more than half of Medicaid-only applicants completed an in-person interview.



Filing Date

Local agencies were asked to submit documentation of the signature that established the Medicaid filing date. Documentation submitted included the following:

- CARES combined application form (CAF)
  After an in-person interview, the information provided is printed and the applicant signs the last page to acknowledge rights and responsibilities and attest to the accuracy of the data provided.

- Client registration printout: prior to the in-person interview, the applicant provides his/her name, address and signature on a printout of the registration information provided to establish a filing date.

- Wisconsin Family Medicaid and BadgerCare Application (DES-12277): the two-page, mail-in, Medicaid-only application form.

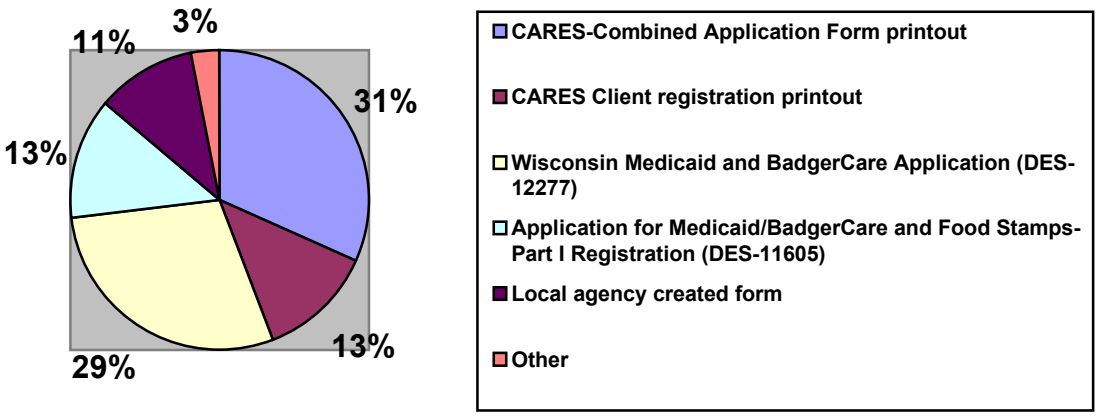
- Application for Medicaid/BadgerCare and Food Stamps- Part 1 Registration (DES-11605): the two-page Medicaid and Food Stamp registration form. This form became obsolete in February 2003 after the separate Medicaid and Food Stamp registration forms were introduced.

- Local agency created form: numerous agencies created their own application and registration forms. Some of the forms contained questions not asked on the mail-in Medicaid application form, apparently to screen eligibility for other programs of assistance. Other versions of county-created forms contained typographical errors and misinformation (e.g. you must provide written verification within seven days of a verbal request). We speculate that agencies created their own application and registration forms because Wisconsin's combined (Food Stamps and Medicaid) application form became obsolete yet many applicants were

interested in applying for both programs, and/or because there was perception that Department forms did not meet local agency needs.

- Other- A small number of applicants used the following forms to apply for Medicaid: DES-12447 (Spanish version of the two-page, Medicaid-only application form), DES-11154, DES-2034 (the Elderly/Blind/Disabled, Medicaid-only application form), and DES-2035 (Medicaid/Food Stamp application and review form). One applicant established a Medicaid filing date with a phone call.

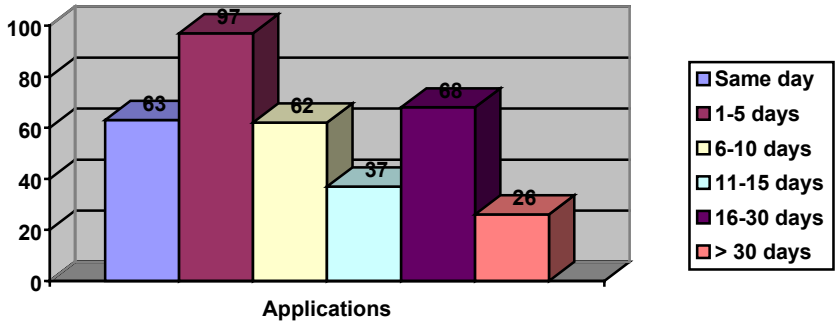
The distribution of application forms used was as follows:



Processing Time

Although historical data about the length of processing time prior to program simplification and streamlined verification changes is not available, the impact of program changes on the timeliness of application processing was evaluated to the fullest extent possible. The application filing and confirmation dates were compared and differences according to application method were assessed.

Of the applications reviewed, 327 (93%) were processed within the required 30-day timeframe and the majority (63%) were processed within ten days. For all of the cases reviewed, the average amount of time between filing and confirmation dates was 11 days. On average, it took 12 days to process Medicaid-only applications.



For those applications not processed within the 30-day timeframe, it was assumed that the delay was likely because Food Stamp or TANF programs were requested and Medicaid was not confirmed until the other program's more prescriptive verification requirements were fulfilled. However, of the 26 applications not processed within the 30-day timeframe, only nine (35%) applicants also received benefits from programs with more prescriptive verification requirements during the review period.

In 63 (18%) of the sample cases, eligibility was confirmed on the same date that the request for Medicaid was established. Thirty-six (57%) of those were Medicaid-only applications and of those, eligibility was confirmed for 30 cases (83%) after an in-person interview and six (17%) were processed on the same date that the mail-in application form was received.

For the thirty Medicaid-only cases confirmed after an in-person interview on the same date of Medicaid request, perhaps applicants were unwilling to come to the agency to establish a filing date prior to their scheduled interview or agencies were available to see applicants on the same day as Medicaid was requested. Either way, Medicaid eligibility (particularly for BadgerCare) could have been delayed because of the in-person interview. Information about this possibility and whether applicants were made aware of their application choices and the significance of the application filing date was not measured in this evaluation.

The Impacts of Program Simplification on the Accuracy of Eligibility Determinations

Active Review Results

The non-financial and financial eligibility of household members in the fiscal test group was reviewed for 353 cases to determine if the Medicaid certification was correct. The non-financial eligibility review included an examination of residency, child support and SSN cooperation requirements, household composition/living arrangement, age, and citizenship. Financial eligibility was tested at 185% of the federal poverty level in the month of application and 200% of the federal poverty level in the subsequent month.

Reviewers used third party data exchange resources and collateral contacts to obtain information about the recipient's income, age, state of residency, household composition, and cooperation with social security requirements and the child support agency. The focus of these case reviews was whether the certification was correct: Did the Medicaid recipient meet all non-financial and eligibility requirements? However, information about application processing (e.g. number of days from request to confirmation, application method, eligibility for other public assistance programs, etc.) was also collected for evaluation.

Medicaid costs that were incurred as the result of an incorrect certification were not a consideration in the designation of error. For the purpose of this evaluation, a certification error was defined as the placement of Medicaid eligibility on the MMIS file for an ineligible person. In addition, although the review focused primarily on the month of application and subsequent month, the agency was notified if a potential error in the remaining months of the certification period was known to the reviewer. If, after further review, it was determined that an error occurred, it was noted as such and included in the error statistics.

Of the 353 active cases reviewed, 324 cases contained certifications considered correct for quality assurance purposes and 29 cases contained a certification error.

Non-financial Errors

Of the 29 cases that contained a certification error, eight were due to non-financial reasons as follows:

- Residency
  In one case the family moved out of state in the fifth month after certification but failed to report the change. The local agency could have considered residency "questionable" when notification was sent to the recipient and the worker that the food stamp electronic benefit card had not been used in 60 days. There was a second opportunity to question Wisconsin residency when the Food Stamp six-month review was not completed. However, Medicaid eligibility continued and Wisconsin continued to make payments to the Health Maintenance Organization throughout the certification period. In another case, the family stated that they moved to Wisconsin in March 2002, but Medicaid eligibility was certified effective January 1, 2002.

- Child Support Cooperation
  In two cases, women who refused to cooperate with the child support agency were incorrectly certified for Medicaid. In one of these cases, the recipient lived with the father of her four children as evidenced by the fact that all of them were given his surname, but paternity had not been established for any of them. His income was therefore not counted in their eligibility determination and if it had been, the children would have been ineligible.

- Household composition
  In two of the cases reviewed, the minor children who made the applicant non-financially eligible for Medicaid were not in fact living with that parent at the time s/he applied. In another case, the children moved out of the household during the certification period but the change was not reported to the eligibility worker.

- SSN cooperation
  In one case a social security number (or proof that a number had been applied for) was not requested prior to Medicaid certification. The family failed to respond to the eligibility worker's request to provide a social security number.

Summary of certification errors that occurred for non-financial reasons:

QA Case Number	Certifying Agency	Error Description
		Residency
0102033	Milwaukee	
0302003	Milwaukee	
		Household composition
0302017	Langlade	
0602026	Milwaukee	
0902027	Milwaukee	
		Child support cooperation
1101008	Milwaukee	
1101016	Lincoln	
		Other
0902029	Milwaukee	SSN cooperation requirements

Financial Errors

All except for one of the twenty-one certification errors due to financial reasons occurred because income was not accurately reported at application or during the certification period. In one of the financial error cases, income was accurately reported and verified but was not correctly budgeted in CARES.

Fifteen certification errors occurred because income was not accurately reported and/or budgeted at application. Several applications were prompted by a job loss but the applicant failed to report the wages received during the month of application. In these cases the applicant correctly indicated that s/he was not working, but apparently did not understand that wages received during the month of application also needed to be reported and this information was not collected prior to Medicaid certification.

Other certification errors occurred because the applicants underestimated or misreported their current income on the application form. Except for one case listed below, verification of income was not requested or provided prior to Medicaid certification. Below is a summary of certification errors that resulted from inaccurate report of income at application:

QA Case Number	Certifying Agency
0402030	Ashland
1001027	Brown
0102014	Dane
1201020	Green
0402031	Iowa
0802027	Manitowoc
0702003	Milwaukee
0702018	Milwaukee
0702001	Milwaukee
0902030	Milwaukee
1001009	Milwaukee
1101003	Milwaukee
0802034	Oneida
0802031	Ozaukee
0102008	Winnebago

Six certification errors occurred because income changes were not reported during the certification period. Although the review focused primarily on the month of application and subsequent month, the agency was notified if a potential error in the remaining months of the certification period was known to the reviewer. In the cases listed below, income increased during the certification period but the change was not reported by the recipient or identified through data exchange because of the delay in the receipt of discrepant wage information. In all of these cases, the increased income resulted in ineligibility. Below is a summary of certification errors that resulted from failure to report income changes during the certification period:

QA Case Number	Agency
1101012	Door
0302019	Milwaukee
0402001	Milwaukee
0902031	Racine
0102022	Shawano
1001004	Waukesha

Negative Review Results

Eligibility workers were instructed to seek verification of non-mandatory items only when the applicant/recipient's self-declared statements were considered "questionable" according to Department criteria. In addition, eligibility workers were instructed to document in the CARES record why an item was deemed "questionable." Eligibility should not be denied or terminated unless the applicant/recipient is properly notified about what is required, is allowed adequate time to produce the verification, and has the power to produce the verification but fails to do so within the required timeframe.

If an eligibility worker deemed information "questionable," reviewers noted whether the reason why information was determined "questionable" was documented in the CARES record. In

addition, reviewers determined if the applicant/recipient was properly notified of application requirements and allowed a minimum of ten days to provide the required information and/or verification before the negative action was taken.

A random sample of 228 family Medicaid cases in which a negative case action (denial or termination of Medicaid eligibility) occurred were reviewed to determine if proper notification and adequate time was allowed before the negative action was taken. Of the 228 negative cases reviewed, 206 (90%) were determined to be correct for quality assurance purposes. However, 22 cases in the negative sample and five cases in the active sample contained what reviewers considered an incorrect denial or termination of Medicaid eligibility.

Negative Sample

Although the focus of negative case reviews was the impact of streamlined verification requirements, the sample contained cases where eligibility was denied or terminated for primary reasons other those requested for the sample universe. For example, the sample included cases where Medicaid eligibility was denied for income or non-financial reasons or terminated because an eligibility review was not completed.

However, the majority (89%) of negative sample cases involved denial or termination of Medicaid eligibility because the applicant or recipient "did not verify information" or "failed to provide information" and useful information was gathered about areas to target for policy clarification and process improvement.

Numerical Reason Code	Denial/Termination Text	Number of sample cases where Medicaid was denied or terminated for this reason
13	Income reported exceeds the program eligibility standard.	4
14	Income exceeds the net income limit.	7
38	Primary person failed to verify identity.	0
42	Failed to cooperate in establishing eligibility.	0
50	Withdrew entire application.	0
51	Direct Child Support payments increased.	1
54	Declined this type of aid.	1
78	Failed to complete the application.	0
112	Did not verify information.	194
113	Failed to provide information.	9
238	The Primary Person does not reside in Wisconsin.	1
277	There is no qualifying child under 19 in the household.	2
355	The target is no longer under six years of age.	1
368	SFU could not build this AG.	7

Denials

In seven of the negative cases reviewed, eligibility was denied because mandatory verification (e.g. pregnancy) was not provided. In the other cases eligibility was denied because the recipient failed to provide information or verification of a non-mandatory item. In a significant number of cases the reason why income information or address information was deemed "questionable" was not documented in the CARES record or apparent to reviewers. In addition, the verification requirements of the Food Stamp program sometimes impacted the Medicaid eligibility determination. However, denial of Medicaid eligibility was considered to be correct if verification was requested in writing and at least ten days (or the balance of the 30-day application processing period) had passed before action to deny eligibility was taken.

The denial of Medicaid eligibility was reviewed for 52 cases and was considered correct in 45 cases. In the majority of cases applicants were properly notified of information and verification requirements, the reasons why self-declared information was deemed "questionable" was documented in the CARES record, and applicants were allowed adequate time to produce the requested information before action was taken to deny eligibility. However, the seven denial errors found in the negative sample and four denial errors found in the active case sample are described below:

Non financial:
In one case the family's eligibility was denied because their Medicaid case in a neighboring state had not yet closed. The family was physically present in Wisconsin and expressed a desire to reside here, thus the denial of eligibility in this case was contrary to policy and therefore considered incorrect.

In two cases the eligibility worker made a keying error which resulted in the incorrect denial of eligibility. In the first case a mother's eligibility was incorrectly denied because household relationships were incorrectly coded and (according to the information in CARES) she was not pregnant or the parent of a minor child. In the other case, the worker incorrectly indicated in CARES that the applicant was not requesting BadgerCare.

Verification and notice requirements:
In four cases verification of income or address was requested, but action was taken to deny eligibility on the same day that the notification of verification requirements was issued. In one case, verification was not requested before negative action was taken. These denials were considered incorrect because the applicants were either not notified of required verification, or were not allowed adequate time to produce verification before the application was denied.

In two cases, verification of the applicants' income was requested and eligibility was denied when it was not provided. The applicant provided verification of income in a subsequent application, and it validated their self-declared statements. The reason why the applicant's statements were deemed "questionable" was not documented in the CARES record or obvious to reviewers and agency staff. In both of these cases the requirement to provide verification was contrary to policy and resulted in an unnecessary delay in eligibility.

In one case, verification of rent/utility expenses, adoption assistance income and assets was requested for a food stamp and Medicaid application. When these items were not provided,

eligibility for both programs was denied. This denial was considered to be in error because none of the verification items requested are considered in determining Medicaid eligibility.

Summary of incorrect denials

QA Review Number	Agency	Error Description
		Failure to allow adequate time to produce verification before eligibility was denied (verification and denial notices issued on the same day).
0802501	Brown	
0702501	Milwaukee	
0102502	Rock	
0802503	Walworth	
		Unnecessary delay due to over-verification
0102007	Green	
0202501	Racine	
		Keying error
1001029	Milwaukee	Worker indicated that applicants were not requesting BadgerCare.
0702024	Sheboygan	Worker coded household relationships incorrectly.
		Other:
1001001	Dane	Residency
1201502	Jefferson	There is no evidence in CARES that verification of income was requested before eligibility was denied.
0502504	Milwaukee	Denied eligibility for failure to verify information that did not affect family Medicaid eligibility (rent/utility expenses, adoption assistance income and assets)

Although it was apparent from case reviews that verification was sometimes requested when self-declared information did not meet the Department's "questionable" criteria, reviewers did not collect information about recipient circumstances at that time or deem those cases in error. Reviewers were usually unable to determine if the outcome would have changed if requested verification had been submitted, and the potential for unnecessary denial of eligibility was therefore not fully assessed during this evaluation. However, corrective action was taken in the few cases where it was clear that the applicant was eligible during months in which Medicaid eligibility had been denied. And in a number of active cases reviewed, Medicaid was certified because applicants provided verification that validated their self-declared statements.

Terminations

The termination of Medicaid eligibility was reviewed for a random sample of 176 cases. Of those, the termination of Medicaid eligibility in 161 (91%) cases was considered correct: the recipient was properly notified of verification requirements and adequate time to produce the information/verification was allowed before eligibility was terminated. The notification of

verification requirements was not required when the recipient requested case closure or when mail was returned to the agency by the post office without a forwarding address.

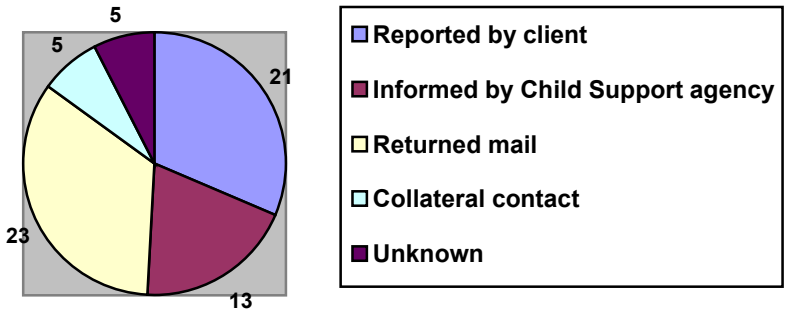
The CARES system prevents termination of eligibility with less than a ten-day notice. Therefore, in all of the cases reviewed, recipients were notified of the termination of Medicaid eligibility at least ten days prior to the effective date. Advance notice is even provided when it is not necessary (e.g. the recipient has permanently moved out of Wisconsin, agency mail is returned by the post office without a forwarding order, etc.) In addition, termination notices state: "If you have questions or think this action is wrong, call the person listed at the top of this letter. Also, you have the right to appeal." Presumably, if the recipient suspected eligibility was wrongly terminated, s/he understood that the eligibility worker could be contacted for additional information about how to restore eligibility or s/he could appeal the decision through the fair hearing process.

The primary reasons why eligibility was terminated in the sample cases were because the recipient had a change in address or income and failed to respond to the eligibility worker's request for additional information and/or verification. Terminations resulted from failure to verify address in 67 (38%) of the sample cases, and from failure to verify income in 87 (49%) of the sample cases. Other terminations in the sample resulted from failure to verify non-financial or mandatory information such as social security number or pregnancy, or because an eligibility review was not completed. In several of the sample cases eligibility was terminated per the recipient's request.

Recipients notified the agency of their change in address in 21 (31%) of the 67 sample cases where eligibility was terminated for failure to verify address. In nine of the cases where a change of address was reported, the recipient moved within Wisconsin. In six of those cases the recipient moved out of state. In five (7%) of these cases, the address change was discovered through a fraud investigation, through contact with a friend/family member of a recipient or through the eligibility worker for a companion case. In another five (7%) of these cases, the source of information about the address change is not known.

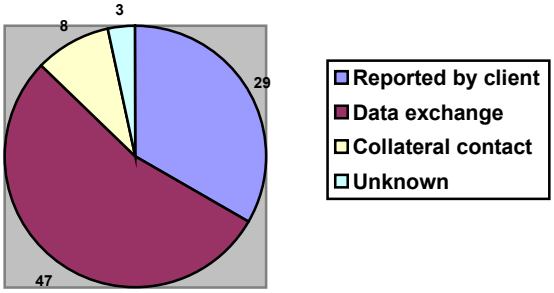
The recipient lost contact with the agency in 40 (60%) of the sample cases where Medicaid eligibility was terminated for failure to verify address. In 23 (58%) of the cases where loss of contact occurred, mail sent to the recipient was returned to the agency and did not contain a forwarding order. In 13 (33%) of the cases where the recipient lost contact with the agency, the eligibility worker was notified of an address change by the child support agency. Inappropriate expenditures are possible when recipients enrolled in a health maintenance organization (HMO) fail to notify the agency of a permanent move out of state, but this was not measured because where and when these recipients moved is not known.

Source of change for terminations due to failure to verify address



In 87 of the cases reviewed, Medicaid eligibility was terminated when recipient failed to respond to an eligibility worker's request for verification of income. In 47 (54%) of those cases, the eligibility worker was notified via data exchange that the recipient had new, unreported income but the recipient failed to respond to the worker's request for additional information and/or verification. The recipient contacted the agency to report an income change in 29 (33%) of these cases, and in 8 (9%) of these cases the worker became aware of the income change through other means such as an anonymous tip, newspaper announcement, parole officer, etc. The method by which the agency became aware of an income change was not documented in 3 (4%) of the cases where eligibility was terminated for failure to verify income.

Source of change information for terminations due to unverified income



Clearly recipients do not always notify the agency of changes that impact their eligibility. In the 146 cases where a change occurred and the source of change information could be determined, 34% were reported by the recipient and 66% were discovered through other sources such as returned mail and data exchange resources (local child support agencies and Wisconsin's Division of Unemployment Insurance).

Below is a description of the termination errors that occurred:

- County transfer policy:
  In two cases, the recipients moved and although the case was correctly transferred to the new county of residence, eligibility was terminated when the recipients failed to reapply for Medicaid within ten days. According to policy, the new county of residence should request information about changes in circumstance but cannot require recipients to reapply or complete an eligibility review.

- Notification errors:
  Termination of Medicaid eligibility was considered to be incorrect in 12 of the cases reviewed because the recipient was not notified of verification requirements before adverse action was taken. In two cases the agency failed to allow adequate time to produce the required information/verification before action was taken to terminate eligibility. In both of these cases eligibility was terminated one-month earlier than it would have been if the recipient had been allowed ten days to produce verification before action was taken to terminate eligibility.

  It is important to note that failure to allow a minimum of ten days after verification was requested before action was taken to terminate eligibility occurred in a number of other cases as well. However, in those cases if the eligibility worker had waited ten days before taking action, the termination effective date would not have changed. For example, if verification was requested on November 5th and notice of closure was sent on November 10th, the recipient was not allowed adequate time to produce required verification. However, if ten days had passed after the verification request was issued and the closure notice had been sent on November 15th, eligibility would still have ended on November 30th. Although these cases contained a procedural error, the termination date was considered correct.

Summary of the fifteen termination errors in the negative sample and one termination error in the active sample:

QA Review Number	Agency	Error Description
		Failure to provide notification of verification requirements before action was taken to terminate eligibility.
0102714	Dane	
1101704	Douglas	
1201712	Douglas	
0602709	Grant	
0602713	Iron	
0302711	Kenosha	
0902714	Marquette	
0702707	Pierce	
1001706	Rusk	
1101711	Milwaukee	
0502701	Milwaukee	

QA Review Number	Agency	Error Description
0202715	Waushara	
		Failure to allow adequate time to produce requested verification before action was taken to terminate eligibility:
0402715	Dane	
0102712	Rock	
		County transfer:
1201030	Dane	
1101712	Washington	

Program Integrity Issues

A number of program integrity issues were identified as a result of the active and negative case reviews:

Data Exchange

Although it did not usually result in a certification error, it was apparent through case reviews that recipients frequently fail to report income accurately at application and/or fail to report income changes during the certification period. In only 34% of the termination cases reviewed, address and/or income changes were reported by the recipient.

In 39% of the termination cases reviewed, discovery of unreported income and/or address changes was made by the eligibility worker through data exchange. Clearly data exchange resources are an effective means to prevent eligibility errors. However, data exchange currently cannot be used to obtain information about wages earned in neighboring states, self-employed recipients, undocumented immigrants, or recipients working under a name and/or SSN that is different than that provided to the agency. When data exchange is unavailable, there is no means to compare applicants' self-declared statements to third party data in order to detect potential eligibility errors.

Wage information for two recipients in the active sample was not available through Wisconsin's wage match, despite the fact that applicants stated that they had numerous jobs in Wisconsin. In addition, in three of the cases reviewed, wage information for an individual not known to CARES was retrieved through the automated data exchange when the Medicaid recipient's social security number was used. This meant that for these cases, third party wage information could not be compared to recipient's self-declared information to detect errors.

Finally, in one case the family moved from Wisconsin to a neighboring state five months after Medicaid was certified but failed to report this change to the eligibility worker. If this had been a fee-for-service case, incorrect payments during the remainder of the certification period would likely not have been made. An automated match to detect receipt of public assistance in another state might provide a means to alert eligibility workers so that payments made to health maintenance organizations for individuals who no longer live in Wisconsin could be prevented.

Policy and Procedures

It was apparent through case reviews that policies and procedures for the eligibility determination of non-qualifying immigrants and residents of institutions for mental disease were not always clearly understood by eligibility workers. For example, in several cases the institutionalized minor was certified for Medicaid for several months when s/he was institutionalized for several days and parental financial and non-financial information was not collected.

In addition, clarification of policies and procedures for processing Medicaid applications, eligibility reviews and reported changes is also warranted. For example, in the error cases when termination of a job prompted Medicaid application, the applicant correctly stated on the application form that s/he was not working. However, information about income received during the month of application was not reported by the applicant or collected by the eligibility worker and an incorrect certification resulted.

Household Composition

In a number of cases household composition could not be determined with certainty during the review, but the certification was considered correct based on information available. In several of these cases there was indication that a parent not reported on the application may have been living in the household, but more extensive investigation was not conducted as part of the review. In addition, several applicants younger than 17 years of age were certified for Medicaid when information about parental income was not collected. If applicants/recipients report little or no income, it is prudent to monitor the case closely for changes and/or seek information about how shelter and other living expenses are paid.

In several other cases, recipients failed to report a household composition change. In one of the sample cases the eligibility worker noticed the marriage announcement of a recipient in the local newspaper; the recipient's eligibility was terminated after her spouse's income was counted in her eligibility determination. In other cases recipients failed to report that the children that qualified them for Medicaid had left the home.

Wisconsin's Recent Program Integrity Activities

Data Exchange Enhancements

A work group was formed in 2002 to identify problems, explore options and make recommendations for improvement to the data exchange processes. The primary goals of the work group were to improve the efficiency and effectiveness of the data exchange processes.

Enhancements made in March 2003 included the following:

- A new data exchange summary screen was developed for use as a caseload management tool. In the past it was necessary for workers to query data exchange information using each individual's case number or personal identification number (PIN). As of March 2003, eligibility workers can query data exchange information for all individuals in the case by CARES case number.

- The in-state data exchange matches that provide wage information were enhanced to improve the relevance and timeliness of the information provided. The data exchange which provides information to eligibility workers about recipients who were recently hired in Wisconsin (the "new hire" match) now occurs weekly instead of monthly so that information can be acted upon sooner. In addition, the targeting criteria for quarterly wage information was changed so that eligibility workers are alerted only when there is a significant discrepancy for a recipient who received Medicaid or food stamp benefits during the entire three months of the quarter.

- When unemployment compensation benefits begin or end, it usually means that a job has started or ended. Eligibility workers are now alerted when the information in CARES varies from the information provided from the Division of Unemployment Insurance (DUI) by more than $100.

- Outdated data exchange information was purged from the CARES system so that eligibility workers could focus on more current and relevant information.

Communication Enhancements

The Department is committed to work in partnership with local agencies to operate programs effectively. Several changes to improve communication with local agencies have already occurred:

A New Web Page

The Department recently developed a "one stop shop" for IM-related issues. The "Eligibility Management" web page is found at http://www.dhfs.state.wi.us/em/index.htm and includes forms and publications, CARES update information, and links to handbooks, manuals and other related materials.

Changes to the Medicaid Eligibility Handbook

The Medicaid Eligibility Handbook became available online in July 2003. In addition, chapters about application processing and non-financial requirements were added, and the chapter on corrective action and benefit recovery was expanded and clarified.

Future Initiatives to Reduce Agency Workload and Improve Communication

In addition to the workload reduction changes that have already been implemented, the Department is also working on the following:

Automated Case Directory

The Department is currently developing a tool for eligibility workers that provides improved access to timely data for making decisions, managing workload, detecting and preventing fraud, and improving program integrity. The Department plans to replace many of the current CARES reports and electronic alerts which workers find difficult to use with a comprehensive database of their cases through the Internet and standard processing tools like Microsoft Access and Excel. The spreadsheet and database software will allow workers to sort data in ways that assist them in identifying, coordinating and scheduling work tasks. This will enable the Department to discontinue production of the existing costly paper-based case directory report and better meet user needs. The first phase of the automated case directory will be implemented in September 2003.

Web-based Library and Online Handbooks

An Income Maintenance Program reference library will be developed to build upon existing interactive policy materials and internet-based training functions. The project will create an integrated Medicaid and Food Stamp policy and process library that will be seamlessly connected to the web-based user interface. This will allow workers to view policy and process information that relates to the information being entered or changed. This enhancement is scheduled to occur in 2004, after the web-based user interface is complete.

Centralized Change Center Option

Change centers for the Medicaid and Food Stamp programs have been successfully implemented in two of Wisconsin's counties. The concept of the change center is to create a dedicated unit of eligibility workers to whom program participants can report changes in circumstance. The unit has access to the telecommunications and CARES technology to enable them to quickly and effectively access case records, record the change, request necessary verification, and re-determine eligibility. A statewide change center is currently being considered, and would integrate the concepts of the existing change centers with the centralized state model currently being used for Wisconsin's SeniorCare program.

Screening Tools

A web-based tool for applicants and local agency staff to assess Medicaid and Food Stamp eligibility will be developed. The tool will allow inexperienced internet users to enter information about his/her household and receive a response about potential eligibility for Medicaid and Food Stamps. A screening tool has potential for increasing participation, preventing unnecessary denials and terminations, and reducing local agency workload.

CARES Enhancements

Because case reviews were done some time after the case was initially processed, many of the CARES issues identified in error cases have already been addressed:

Child Support Cooperation

Two certification errors occurred because the recipient refused to cooperate with the Child Support Agency (without good cause) but until recently, the CARES system did not adequately support this policy. This problem was corrected in March 2003 and now eligibility correctly fails if an applicant or recipient refuses to cooperate with the child support agency.

Grace Month

In a number of cases reviewed, eligibility was properly terminated and adequate notice was provided to the recipient but eligibility remained on file on the Medicaid Management Information System (MMIS) for an additional month. In some cases this resulted in incorrect payments to the recipients' health maintenance organization. This closure problem was fixed in March 2003.

Adoption Assistance and Kinship Care

In several of the cases reviewed, adoption assistance or Kinship Care payments were entered as the parent's income rather than the child's. Although it did not negatively impact eligibility in these cases, the income was counted in the determination when according to policy it should always be disregarded.

Re-engineering of Alerts

In April 2003, several changes were made to CARES to improve the functionality of alerts (automated reminder notes) that eligibility workers receive when action needs to be taken on a case. A new "alert help" screen was developed to provide specific information about the action needed. In addition, the sort order a worker uses to manage alerts is now retained for the remainder of the workday.

A "Self-declared" Verification Code

Although Medicaid, Food Stamp, and TANF programs have different verification requirements, eligibility determinations for all of them are processed in the CARES system. In order to

minimize the potential for error in other programs of assistance, eligibility workers needed a means to indicate that information was self-declared by the applicant rather than verified by a third-party source. A "self-declared" verification code was added to CARES in May 2003.

Future CARES Enhancements

In addition to the CARES enhancements described above, the initiatives described below are scheduled within the next year. All of them are intended to reduce local agency workload, improve customer service and increase the accuracy of eligibility determinations for both the Medicaid and Food Stamp Programs.

Automatic Update of Unemployment Compensation Benefit and New Hire Information

Data from Wisconsin's Division of Unemployment Insurance (DUI) about the hire and/or receipt of unemployment insurance will be refined and provided to eligibility workers in a more efficient, effective and automated way.

Mini Driver-Flows

Within the next year, the Department plans to develop mini driver-flows for Medicaid that better align with program policy and application forms. The goal is to collect information about the circumstances of those in the Medicaid fiscal test group and then structure remaining questions accordingly. For example, if an individual is elderly/disabled, ask about assets and require verification in order to determine his/her eligibility.

CARES Web-based User Interface

The current CARES mainframe data entry interface will be replaced with an integrated web-based user interface. By shifting from the mainframe environment to the web environment, CARES will have a user interface that is easier to use and will reinforce program policies and processes that focus on our goals for streamlining enrollment processes while maintaining program integrity. This enhancement is scheduled for August 2004.

Data Exchange Enhancements

A match with Wisconsin's Department of Corrections will be established to detect Medicaid recipients who are incarcerated. The Department also plans to simplify the processes for workers to obtain and respond to information that could impact the case. In addition, the Department will enhance the processes by which eligibility workers provide feedback about the usefulness of the data received through third party data exchange resources. This will allow the Department to better evaluate and refine targeting techniques.

Recommendations

It is recommended that the following improvement ideas be further evaluated, to determine if they are cost effective and would promote the Department's goals of reducing workload and maintaining excellent customer service and program integrity:

Forms and Publications

Medicaid Application Form

Many of the eligibility workers and advocacy agencies surveyed recommended the mail-in application forms be revised to collect all information needed to determine eligibility and reduce the number of follow-up contacts. A number of the suggestions listed below have already been implemented, or will be implemented in the near future.

Suggestions from eligibility workers and advocates for the mail-in Medicaid application form (DES-12277) included the following:

- Synchronize application information with the CARES driver-flows and collect only (and all) information needed to determine Medicaid eligibility.
- Collect more information about non-financial circumstances and income received in previous months when applicants are requesting retroactive eligibility.
- Collect more information about medical insurance (e.g. insurance company address/phone, the reason why insurance ended, etc.).
- Provide additional space and collect more information about parents. Restructure the absent parent questions to clarify required information, and place pregnancy questions nearby with instruction to provide information about the father of an unborn child when applicable.
- Ask the applicant if s/he has any questions about Medicaid and if so, whether s/he would like the agency to contact him/her. Provide a place for applicants to indicate comments and/or provide explanation.
- Provide a checklist for the applicant to complete. If a question is answered "yes," instruct the applicant to submit required verification with the application form.
- Simplify terms on the form and place examples near the questions. For example, applicants do not always understand the term "unearned income" and mistakenly answer the question no.
- Provide clear instructions about how to calculate gross income and collect information about employment start/end dates. Alter the questions to collect information about hourly rate, number of hours per week, pay period schedule, etc.
- Collect details about self-employment that align with the CARES screen and tax forms (gross income, expenses, depreciation)

Brochures and Fact Sheets

Many survey respondents stated workers prefer a face-to-face application interview so customers better understand their rights and responsibilities. Workers also expressed a need for written materials that better explain deductibles, BadgerCare premiums, HMO enrollment procedures, birthing costs for unmarried pregnant women, reporting requirements, Medicaid transportation, etc.

Combined Application Form

Many applicants are interested in applying for both Medicaid and Food Stamps. It would benefit customers and the agencies that serve them if an application form for both programs was available.

Notice Changes

Expand Verification Text in Notices

It would be helpful to add specific information in verification and denial/termination notices to include:

- Whether information or verification is required; and
- The exact reason why the negative action occurred.

Current termination notice text says: "Information needed to determine eligibility for this program has not been verified. See your verification checklist or contact your worker for more information." In some of the negative cases reviewed, applicants/recipients were not notified of verification requirements before action was taken to deny or terminate eligibility.

More specific notices would enhance applicant/recipient understanding and reduce local agency workload because there would presumably be fewer phone calls from applicants and recipients. For example, a denial notice could state: "Your Medicaid (or BadgerCare) eligibility is ending because you failed to provide proof of your pregnancy and information about your income."

In addition, it might be beneficial to add text about how an individual can prevent termination of their Medicaid benefits, procedures to re-open their case and/or the right to reapply and request an eligibility re-determination for previous months.

Evaluate Department Publications and CARES Notices

Some agencies have created forms and publications, because they believe Department materials were not available or did not meet community-specific needs. Although some of the local agency-created forms and publications were accurate and informative, others did not contain adequate or correct information about Medicaid rights and responsibilities. It is recommended that the Department take steps to ensure that informational materials are issued timely as program changes occur so that local agencies have the resources they need and to assure consistency statewide.

Emphasize the Importance of Change Reporting Requirements

Analysis of data from case reviews indicates recipients do not always report changes in circumstances that affect their Medicaid eligibility. The importance of change reporting and the consequences of failing to do so should be clearly communicated in eligibility notices.

Emphasize Client Choice of Application and Review Method

Currently Medicaid recipients are not notified through CARES notices of their choices for eligibility review method. In several cases reviewed it was noted that a Medicaid eligibility review "had" to be done by phone because the recipient was unable to keep the appointment for an in-person interview. Further analysis about client awareness of the mail-in application and review option is warranted.

Data Exchange Enhancements and Alternatives

Continue Efforts to Improve the Timeliness and Accuracy of Third Party Data and Simplify the Data Exchange Processes for Workers

Timely and accurate information received through data exchange minimizes the potential for eligibility errors. Opportunities to increase the accuracy and timeliness of important eligibility information will be further explored and taken when determined to be cost effective. In addition, the process by which workers receive and act upon the information received is also important and efforts to improve this process will continue.

It may also be beneficial to explore opportunities to obtain automated information about wages and public assistance received in other states by Wisconsin Medicaid recipients. These matches have potential to prevent incorrect payments for recipients who have moved permanently from Wisconsin, and increase the detection of income errors in cases where the recipient (or an individual who is legally responsible for him/her) is employed in a neighboring state or by an employer that does not report to Wisconsin's Division of Unemployment Insurance.

If data exchange is unavailable, there is no means to compare applicant's self-declared statements with third party data and this increases the potential for inaccurate eligibility determinations. Applicants for whom data exchange is generally unavailable include: non-applicants, non-citizens, Wisconsin residents who work out of state, self-employed persons and those persons whose employers report wages to another state agency. The Department will continue to evaluate current policy, and consider whether verification should be required when third party data exchange information is unavailable.

Additional Evaluation

Ongoing Quality Assurance Reviews

If resources are available, it is recommended that the Department continue to conduct Medicaid quality assurance reviews.

Customer Surveys

Input from a random sample of Medicaid applicants and recipients would likely yield valuable data for publication and process improvement. Specifically, it would be useful to assess the degree to which applicants and recipients are satisfied with the services they receive and understand the following:

- Choices of method for application and review (mail, phone or in-person),
- Medicaid application process and program requirements such as appeal rights, 30-day processing period, etc.,
- Eligibility and verification notices, and
- Requirement to report changes in circumstance and the potential consequences of eligibility errors.

An Evaluation of the Impact of "Helpers"

Data about individuals who received assistance in the application process from a health care organization or advocacy agency was not collected in all of the case reviews and therefore was not analyzed. It would be useful to know if the processing time, number of follow-up contacts needed, accuracy of information provided, etc. varies among applicants who receive professional assistance and those who do not.

Policy Clarifications and Training

It was apparent through case reviews that Wisconsin's eligibility workers are highly competent and thorough. However, it is recommended that Department policy and training materials continue to be clarified in order to ensure that the following areas are well defined for new and existing eligibility workers:

Application Processing

Complete information about household circumstances and sources of income is needed to accurately determine Medicaid eligibility. In several cases that were dropped from the active sample, income was self-declared but employer contact information was not reported on the application, collected before Medicaid certification or available through data exchange. The Department should emphasize the importance of collecting all information needed to determine eligibility and encourage workers to seek clarification whenever necessary. In addition, a thorough understanding of the policy and procedures for filing date establishment, data exchange expectations, appropriate use of verification codes, etc. is important to ensure program integrity.

Negative Actions and Corrective Action/Benefit Recovery

The process by which eligibility is denied or terminated is important to ensure notice text is accurate and the applicant/recipient clearly understands why the negative action occurred. Unnecessary denials and terminations could be prevented if applicants/recipients clearly understand the problem and methods for resolution.

Information about corrective action procedures could be expanded and further clarified in policy materials. In addition, state statutes do not currently support the recovery of incorrect payments made for some types of client errors (e.g. a client's failure to report non-financial changes during the certification period). It is recommended that state statutes be amended to allow for recovery of all incorrect payments caused by a client error.

Documentation

Documentation of required information/verification in CARES is important and it is strongly recommended that workers use CARES for notification and consistently enter case comments about "questionable" circumstances and/or important case actions. Although workers are encouraged to contact applicants/recipients by phone for information whenever possible because it is usually more thorough and timely, it is important that verbal conversations are documented.

CARES System Enhancements

CARES enhancements to support the non-financial requirement to supply a social security number or cooperate in obtaining one would further align the system with program policy and potentially prevent eligibility errors. Currently, if an applicant fails to provide his/her social security number, CARES will automatically assign a pseudo number and eligibility will not fail for this reason unless a worker recognizes the policy and requests the information.

In addition, it would facilitate program evaluation and monitoring if CARES changes were made so that information about application method (mail, phone, in-person) and Medicaid filing and eligibility confirmation dates were collected. Furthermore, changes to more closely align the CARES system with Medicaid policy around eligibility begin and end dates for cases where eligibility hinges on a mid-month occurrence or when advance notice is not required has potential to minimize inappropriate expenditures. For example, if the agency becomes aware that a family has moved from Wisconsin on July 29th, eligibility does not need to continue through August.

Require Cooperation from Medicaid Recipients and Wisconsin Employers

A number of cases were dropped from the active sample because the Medicaid recipient failed to respond to requests for verification of self-employment income, and/or the recipient's employer failed to respond to requests for verification of income.

Section 49.22 (2m) (a) of Wisconsin Statute states: "The department may request from any person in this state information it determines appropriate and necessary for the administration of the section, ss.49.141 to 49.161, 49.19, 49.46, 49.468 and 49.47 and programs carrying out the purpose of 7 USC 2011 to 2029. Unless access to the information is prohibited or restricted by law, or unless the person has good cause, as determined by the department in accordance with federal law and regulations, for refusing to cooperate, the person shall make a good faith effort to provide this information within seven days after receiving a request under this paragraph."

However, there is no consequence for employers or Medicaid recipients who refuse to provide requested information. Furthermore, section 37.8.3 of the Medicaid Eligibility Handbook states Medicaid eligibility cannot be terminated because a recipient does not verify some past circumstance not affecting current eligibility. The Department should consider a change in law to allow for a consequence.

Conclusion

The 2002 MEQC data yielded valuable information that can be used to measure current performance and target areas for future program and process improvements. However, the impact of program simplification and streamlined verification requirements could not be fully assessed in this evaluation because of the scope of the review.

Forty-two percent of the Medicaid applicants whose cases were reviewed also received Food Stamps and/or Wisconsin's TANF programs (Child Care and Wisconsin Works) during the quality assurance review period. Usually this meant that the Medicaid eligibility determination was affected by that program's more prescriptive verification requirements. And in some Medicaid-only applications, eligibility workers did not fully implement the program simplification and streamlined verification policies and procedures that were outlined in the Operations Memo and Medicaid Eligibility Handbook. It is therefore difficult to fully evaluate the effects of streamlined verification changes.

However, analysis of the case reviews indicated that overall there was a low incidence of errors. Ninety-two percent of the certifications reviewed were considered correct for quality assurance purposes. Of the certification errors that occurred due to excess income, all were Medicaid-only applications and this indicates that in some circumstances additional information and/or verification may be warranted. In addition to the active case reviews, the termination or denial of Medicaid eligibility was reviewed for 228 cases. The eligibility determination was considered correct in 90% of those cases reviewed. In most cases the applicant or recipient was properly notified of verification requirements and adequate time passed before negative action was taken. In addition, in all cases the recipient received at least a ten-day notice before the effective date of eligibility termination. The majority of errors in the negative sample occurred because the agency failed to notify the applicant or recipient of verification requirements before action was taken to deny or terminate eligibility.

Survey data indicates that eligibility workers' perception is that the program simplification and streamlined verification changes have made the application process easier for customers, but have also increased local agency workload. It is apparent after analysis of survey data and case reviews that some eligibility workers did not fully buy-in to the streamlined verification and "questionable" concepts. Perhaps this is because they have seen first-hand that applicants do not always estimate accurately and/or report changes in circumstance and were hesitant to fully implement the changes. The Department recognizes these concerns and with this, has embarked on a number of important initiatives to reduce workload and increase program integrity through enhanced data exchanges.

The Department and local agencies are doing an excellent job in Medicaid administration and, overall, the program simplification and streamlined verification changes are considered a success. However, to further balance program access, local agency workload and program integrity, continued focus on the enhancement of data exchange resources should be considered. In addition, revision of the Medicaid mail-in application forms and further emphasis on corrective action and benefit recovery is recommended.

Attachments

Results of Quality Assurance Reviews by Agency

Agency	Total number of family Medicaid recipients as of 9/02	Number of negative (denial/termination) Cases reviewed	Number of active cases reviewed	Average number of days to process Medicaid application(s)	Number of correct certifications	Number of correct denials or terminations	Number of incorrect eligibility determinations
Adams	2319	1	4	8	4	1	0
Ashland	2389	1	1	2	0	1	1
Barron	4052	3	3	1	3	3	0
Bayfield	1484	1	0	N/A	N/A	1	0
Brown	13720	6	19	7	18	5	2
Burnett	1703	0	1	1	1	N/A	0
Calumet	1508	1	0	N/A	N/A	1	0
Chippewa	4827	2	2	11	2	2	0
Clark	2608	2	3	4	3	2	0
Columbia	2607	2	2	1	2	2	0
Crawford	1510	1	1	8	1	1	0
Dane	19121	22	26	19	25	18	5
Dodge	4140	5	1	4	1	5	0
Door	1541	1	2	3	1	1	1
Douglas	4566	4	2	13	2	2	2
Dunn	3130	2	3	11	3	2	0
Eau Claire	7018	3	7	13	7	3	0
Fond du Lac	5252	2	6	9	6	2	0
Forest	1022	0	1	1	1	N/A	0
Grant	2711	2	4	15	4	1	1
Green	2040	0	10	27	8	N/A	2
Iowa	1273	1	2	0	1	1	1
Iron	695	3	0	N/A	N/A	2	1
Jackson	1787	0	2	27	2	N/A	0
Jefferson	3348	2	4	14	4	1	1
Juneau	2330	0	2	5	2	N/A	0
Kenosha	13036	8	11	11	11	7	1
LaCrosse	6903	7	8	5	8	7	0
Lafayette	896	0	1	5	1	N/A	0
Langlade	2247	2	2	12	1	2	1
Lincoln	1773	1	3	13	2	1	1

Agency	Total number of family Medicaid recipients as of 9/02	Number of negative (denial/termination) Cases reviewed	Number of active cases reviewed	Average number of days to process the application	Number of correct certifications	Number of correct denials or terminations	Number of incorrect eligibility determinations
Manitowoc	4165	2	5	17	4	2	1
Marathon	8006	8	9	15	9	8	0
Marinette	3524	0	2	15	2	N/A	0
Marquette	1324	1	1	36	1	0	1
Milwaukee	141326	37	85	8	71	32	19
Monroe	3697	2	2	7	2	2	0
Oconto	2351	0	2	10	2	N/A	0
Oneida	3031	2	3	11	2	2	1
Outagamie	6597	4	8	17	8	4	0
Ozaukee	1653	0	5	14	4	N/A	1
Pepin	499	0	2	19	2	N/A	0
Pierce	1387	4	2	7	2	3	1
Polk	3097	5	2	2	2	5	0
Portage	4139	1	2	18	2	1	0
Racine	15643	15	13	12	12	14	2
Richland	1580	1	1	11	1	1	0
Rock	13983	16	19	7	19	14	2
Rusk	1721	1	1	0	1	0	1
Sauk	3474	1	6	21	6	1	0
Sawyer	2475	1	2	7	2	1	0
Shawano	2952	3	3	8	2	3	1
Sheboygan	5424	4	10	4	10	3	1
St. Croix	2433	2	1	3	1	2	0
Taylor	1659	1	0	N/A	N/A	1	0
Trempealau	1900	2	1	0	1	2	0
Vernon	2062	1	1	26	1	1	0
Vilas	1275	0	3	6	3	N/A	0
Walworth	4713	4	3	25	3	3	1
Washington	3944	3	3	13	3	2	1
Waukesha	7524	2	10	11	9	2	1
Waupaca	3018	2	3	5	3	2	0
Waushara	2120	3	3	15	3	2	1
Winnebago	8076	7	5	19	4	7	1
Wood	5973	8	2	15	2	8	0
Summary	Total: 412,390	Total: 228	Total: 353	Average: 11	Total: 323	Total: 202	Total: 56

Full Report on the Covering Kids Expansion Project: Simplified Medicaid/BadgerCare Application Survey

"Covering Kids Simplified Application